No. 19-10011

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

STATE OF TEXAS; STATE OF ALABAMA; STATE OF ARIZONA; STATE OF FLORIDA; STATE OF GEORGIA; STATE OF INDIANA; STATE OF KANSAS; STATE OF LOUISIANA; STATE OF MISSISSIPPI, by and through Governor Phil Bryant; STATE OF MISSOURI; STATE OF NEBRASKA; STATE OF NORTH DAKOTA; STATE OF SOUTH CAROLINA; STATE OF SOUTH DAKOTA; STATE OF TENNESSEE; STATE OF UTAH; STATE OF WEST VIRGINIA; STATE OF ARKANSAS; NEILL HURLEY; JOHN NANTZ,

Plaintiffs-Appellees,

v.

UNITED STATES OF AMERICA; UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES; ALEX AZAR, II, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES DEPARTMENT OF INTERNAL REVENUE; CHARLES P. RETTIG, in his Official Capacity as Commissioner of Internal Revenue,

Defendants-Appellants,

STATE OF CALIFORNIA; STATE OF CONNECTICUT; DISTRICT OF COLUMBIA; STATE OF DELAWARE; STATE OF HAWAII; STATE OF ILLINOIS; STATE OF KENTUCKY; STATE OF MASSACHUSETTS; STATE OF NEW JERSEY; STATE OF NEW YORK; STATE OF NORTH CAROLINA; STATE OF OREGON; STATE OF RHODE ISLAND; STATE OF VERMONT; STATE OF VIRGINIA; STATE OF WASHINGTON; STATE OF MINNESOTA,

Intervenor Defendants-Appellants.

On Appeal from the United States District Court
for the Northern District of Texas

BRIEF FOR THE FEDERAL DEFENDANTS

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STATEMENT REGARDING ORAL ARGUMENT

On April 10, 2019, this Court granted the United States' motion to expedite oral argument in this case, and to schedule oral argument during this Court's scheduled sitting in July 2019. The United States respectfully requests the opportunity to present oral argument at that time.

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INTRODUCTION

In *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012) (*NFIB*), the Supreme Court held that a statute requiring individuals to purchase health insurance would exceed Congress's powers under the Commerce and Necessary and Proper Clauses. Although a majority of the Court concluded that the individual mandate contained in the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), was most naturally read as a requirement to purchase health insurance, the Court applied principles of constitutional avoidance to construe the statute as an exercise of Congress's taxing powers. In reaching that construction, the Court emphasized that the mandate was enforced by a penalty that "yield[ed] the essential feature of any tax: It produce[d] at least some revenue for the Government." *NFIB*, 567 U.S. at 564.

Subsequently, in the Tax Cuts and Jobs Act of 2017 (TCJA), Pub. L. No. 115-97, 131 Stat. 2054, Congress eliminated, as of January 1, 2019, the monetary penalty that allowed the individual mandate to be characterized as a tax. Because the individual mandate no longer carries a noncompliance penalty that produces revenue, the savings construction that the Supreme Court adopted, under which the individual mandate was a valid exercise of Congress's taxing powers, is no longer tenable. And the Court has already held that the individual mandate otherwise exceeds Congress's powers under the Commerce and Necessary and Proper Clauses. The individual mandate thus is now unconstitutional.

When one provision in a statute is unconstitutional, other provisions may be upheld only if they are "(1) constitutionally valid, (2) capable of functioning independently, and (3) consistent with Congress' basic objectives in enacting the statute." *United States v. Booker*, 543 U.S. 220, 258-59 (2005) (citations and quotation marks omitted). A court must invalidate other provisions if it is "evident that Congress would not have enacted those provisions which are within its power, independently of those which are not." *Murphy v. NCAA*, 138 S. Ct. 1461, 1482 (2018) (brackets omitted).

As Congress and the Supreme Court have recognized, two sets of ACA provisions were explicitly premised on the existence of the individual mandate: the "guaranteed issue" provisions, which prohibit insurers from denying coverage because of an individual's medical condition or history, and the "community rating" provisions, which prohibit insurers from charging higher premiums because of an individual's medical condition or history (among other things). Congress concluded that the individual mandate would prevent people from taking advantage of these provisions, to the detriment of the health-insurance market, by declining to purchase health insurance until they get sick. Although the 2017 Congress eliminated the mandate's penalty while retaining the rest of the ACA, it left in place both the mandate itself and the 2010 Congress's findings that the mandate was essential to the guaranteed-issue and community-rating provisions—the latter provisions are thus inseverable if this Court holds that the former provision is no longer constitutional.

In the district court, the Department of Justice took the position that the remainder of the ACA was severable, but upon further consideration and review of the district court's opinion, it is the position of the United States that the balance of the ACA also is inseverable and must be struck down. As recognized by the joint dissenters in *NFIB*—the only Justices to reach the severability question—the ACA's provisions were highly interdependent, such that they would not "function in a coherent way and as Congress would have intended" in the absence of the individual mandate and the guaranteed-issue and community-rating provisions. *NFIB*, 567 U.S. at 694 (joint dissent). Again, Congress did not provide otherwise when it eliminated the mandate's penalty, because that alone says nothing about what Congress would have intended if the courts then further set aside the essential ACA elements of the mandate itself *and* the guaranteed-issue and community-rating provisions.

STATEMENT OF JURISDICTION

Plaintiffs' complaint brings claims arising under the Constitution and invokes the district court's jurisdiction under 28 U.S.C. §§ 1331 and 1361. The district court issued a memorandum and order on December 14, 2018, ruling that the individual plaintiffs had Article III standing, the individual mandate is unconstitutional, and the individual mandate is inseverable from the rest of the Act. ROA.2611-2665. On December 30, 2018, the court entered partial final judgment pursuant to Federal Rule of Civil Procedure 54(b) on Count I of the amended complaint (which had sought a declaration that the individual mandate is unconstitutional and not severable from the

remainder of the ACA), but stayed the judgment and stayed further district-court proceedings pending appeal. ROA.2755-2784, 2785. This Court may exercise jurisdiction over proper Rule 54(b) judgments pursuant to 28 U.S.C. § 1291.

Here, the district court entered final judgment on Count I of the amended complaint, thus making clear that it did not intend to provide any more relief with respect to that claim. *See* ROA.2760 (stating that court had "disposed of that claim *entirely*") (brackets omitted). And the court made clear that it regarded the remaining legal claims in the complaint as sufficiently separate from Count I as to require separate proceedings. *See Johnson v. Ocwen Loan Servicing, LLC*, 916 F.3d 505, 508-09 (5th Cir. 2019) (noting that although this Court "has not announced a single test for determining what is a 'claim' for Rule 54(b) purposes," claims can be distinct for such purposes if they rely on at least some different facts or assert different causes of action that "protect[] different interests").[1]

STATEMENT OF THE ISSUES

1. Whether plaintiffs have standing to claim that the ACA's individual mandate is unconstitutional and that the rest of the ACA is inseverable.

[1] The government argued in district court that entry of final judgment for Count I of the amended complaint under Rule 54(b) was not warranted, because the government believed that the amended complaint alleges only one claim with remedial issues that remain to be resolved at subsequent proceedings. ROA.2722-2723. In light of the district court's entry of final judgment as to Count I, which foreclosed any further remedial proceedings with respect to that count, and the court's divergent analysis and treatment of the remaining substantive counts, the government now agrees that this Court has appellate jurisdiction.

2. Whether the ACA's individual mandate is unconstitutional in the absence of any revenue-raising provision.

3. Whether, if the individual mandate is unconstitutional, the rest of the ACA is inseverable in whole or in part.

STATEMENT OF THE CASE

A. Background

1. The Affordable Care Act

The ACA established a framework of economic regulations and incentives restructuring the health-insurance and healthcare industries. Central to the ACA's regulation of the insurance market was 26 U.S.C. § 5000A, known as the "[r]equirement to maintain minimum essential coverage." Subsection (a) of that provision mandates that certain individuals "shall . . . ensure" that they are "covered under minimum essential coverage." 26 U.S.C. § 5000A(a). Subsection (b) of that provision imposes "a penalty," called a "[s]hared responsibility payment," on certain taxpayers who "fail[] to meet the requirement of subsection (a)." *Id.* § 5000A(b). And subsection (c) specifies "[t]he amount of the penalty imposed" for noncompliance. *Id.* § 5000A(c). As initially enacted, the penalty was calculated as a percentage of household income, subject to a floor and a ceiling. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 539 (2012).

Other provisions define the scope of the minimum essential coverage requirement. Subsection (d) states that individuals with religious exemptions,

individuals not lawfully present in the United States, and incarcerated individuals are exempt from the requirement to maintain minimum essential coverage. 26 U.S.C. § 5000A(d). Subsection (e) provides that certain other individuals remain subject to that requirement but are exempt from the penalty for noncompliance. *Id.* § 5000A(e) (including those who cannot afford coverage, taxpayers with income below the filing threshold, members of Indian tribes, those experiencing short coverage gaps, and individuals determined by the Secretary of Health and Human Services to have suffered a hardship with respect to obtaining coverage). And subsection (f) defines "minimum essential coverage" to mean various types of insurance coverage, including government-sponsored programs such as Medicare and Medicaid, *id.* § 5000A(f)(1)(A), as well as eligible employer-sponsored plans and plans offered in the non-group market, *id.* § 5000A(f)(1)(B)-(D); 42 U.S.C. § 18011.

The individual mandate works part and parcel with the other health-insurance reforms in the ACA. The "guaranteed issue" provisions prohibit insurers from denying coverage because of an individual's medical condition or history. 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4(a). And the "community rating" provisions prohibit insurers from charging higher premiums because of an individual's medical condition or history. *Id.* §§ 300gg(a)(1), 300gg-4(b).

When it enacted the ACA, Congress made a statutory finding that the "individual responsibility requirement" to maintain insurance is "essential" to "creating effective health insurance markets in which improved health insurance

products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." 42 U.S.C. § 18091(1), (2)(I). Without the individual mandate, Congress found, "many individuals would wait to purchase health insurance until they needed care." *Id.* § 18091(2)(I). Evidence before Congress suggested that, if the guaranteed-issue and community-rating provisions were not paired with a mandate to purchase insurance, many individuals would "go without insurance when they are healthy, but then have the privilege of throwing themselves on the mercy of community-rated premiums when they fall ill." *Making Health Care Work for American Families: Ensuring Affordable Coverage: Hearing Before the Subcomm. on Health of the H. Comm. on Energy & Commerce*, 111th Cong. 28 (2009) (statement of Uwe E. Reinhardt, Professor of Economics and Public Affairs, Princeton University) (Reinhardt); *see* CBO, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* 23 (Nov. 30, 2009) (an individual mandate "would encourage younger and relatively healthy workers who might otherwise not enroll in their employers' plans to do so"). Congress heard testimony that "[i]t is well known that community-rating and guaranteed issue, coupled with voluntary insurance" rather than an individual mandate, "tends to lead to a death spiral of individual insurance" where premiums rise, the number of people purchasing insurance craters, and insurers flee. *See* Reinhardt, *supra*, at 28.

Title I of the ACA also restructured the health-insurance market in other significant ways. For example, the ACA imposed prohibitions on coverage limits,

requirements to cover dependent children, and essential benefits packages for insurance plans. *See* 42 U.S.C. §§ 300gg-11, 300gg-14(a), 18022. The ACA also created insurance exchanges to allow consumers to shop for insurance plans, and provided subsidies and tax incentives. *See id.* §§ 18031-18044 (creation of insurance exchanges); 26 U.S.C. §§ 4980H, 45R, 36B (tax changes). These provisions were all part of the ACA's effort "to increase the number of Americans covered by health insurance and decrease the cost of health care." *NFIB*, 567 U.S. at 538. The ACA's other Titles also seek to expand health insurance and to control costs, for example by expanding the Medicaid program (Title II), amending the Medicare program (Title III), enacting a range of prevention programs (Title IV), and imposing anti-fraud requirements (Title VI).

2. The Supreme Court's Decision in *NFIB v. Sebelius*

In *NFIB*, the Supreme Court addressed whether "Congress has the power under the Constitution to enact" the individual mandate. 567 U.S. at 532. Chief Justice Roberts explained that, in light of the statutory requirement that individuals "'shall'" maintain coverage, the "most straightforward reading of the mandate is that it commands individuals to purchase insurance." *Id.* at 562 (quoting 26 U.S.C. § 5000A(a)). But the Chief Justice agreed with the four dissenters that the "Commerce Clause does not authorize such a command." *Id.* at 574; *accord id.* at 547-59; *id.* at 649-60 (joint dissent). As a majority of the Court acknowledged, "[t]he Court today holds that our Constitution protects us from federal regulation under the

Commerce Clause so long as we abstain from the regulated activity." *Id.* at 572. The Chief Justice also agreed with the four dissenters that the individual mandate could not be upheld under the Necessary and Proper Clause. *Id.* at 559-61; *accord id.* at 653-54, 658 (joint dissent).

The Supreme Court nonetheless held that the individual mandate was constitutional. Applying the constitutional-avoidance canon, the Chief Justice accepted the argument that the mandate should be interpreted not "as ordering individuals to buy insurance," but rather "as imposing a tax on those who do not buy" health insurance. *NFIB*, 567 U.S. at 562. "Under the mandate," the Chief Justice explained, "if an individual does not maintain health insurance, the only consequence is that he must make an additional payment to the IRS when he pays his taxes." *Id.* at 562-63. "Under that theory, the mandate is not a legal command to buy insurance" and instead "can be regarded as establishing a condition . . . that triggers a tax," given the obligation to adopt "a saving construction" "if fairly possible." *Id.* at 563, 574-75. A majority of the Court agreed that, so construed, the individual mandate was a valid exercise of Congress's taxing power. *Id.* at 570.

Critically, the Court's holding depended on the structure of the shared responsibility payment. The Court explained that the penalty "is paid into the Treasury by 'taxpayer[s]' when they file their tax returns." *NFIB*, 567 U.S. at 563 (alteration in original). As a payment to the U.S. Treasury, the shared responsibility payment "yield[ed] the *essential feature* of any tax: It *produce[d] at least some revenue for the*

Government." *Id.* at 564 (emphases added); *see id.* at 574 (explaining that "Congress's authority under the taxing power is limited to requiring an individual to pay money into the Federal Treasury"). "Indeed, the payment [wa]s expected to raise about $4 billion per year by 2017." *Id.* at 564.

Although the Chief Justice's conclusions regarding the Commerce and Necessary and Proper Clauses and Congress's tax powers were each supported by only four other Justices, all nine Justices in *NFIB* recognized that Congress believed the guaranteed-issue and community-rating provisions could not work without the individual mandate. The Chief Justice explained that "Congress addressed the problem of those who cannot obtain insurance coverage because of preexisting conditions or other health issues" through the ACA's guaranteed-issue and community-rating provisions that "together prohibit insurance companies from denying coverage to those with such conditions or charging unhealthy individuals higher premiums than healthy individuals." *NFIB*, 567 U.S. at 547-48. But "[t]he guaranteed-issue and community-rating reforms do not . . . address the issue of healthy individuals who choose not to purchase insurance to cover potential health care needs." *Id.* at 548. Accordingly, those provisions "threaten to impose massive new costs on insurers, who are required to accept unhealthy individuals but prohibited from charging them rates necessary to pay for their coverage." *Id.*

The Chief Justice explained that the "individual mandate was Congress's solution to these problems" because, "[b]y requiring that individuals purchase health

insurance, the mandate prevents cost shifting by those who would otherwise go without it" and also "forces into the insurance risk pool more healthy individuals, whose premiums on average will be higher than their health care expenses." *NFIB*, 567 U.S. at 548. And in the portion of his opinion rejecting the argument that "Congress has the power under the Necessary and Proper Clause" to enact the mandate because it is an integral part of "the guaranteed-issue and community-rating insurance reforms," the Chief Justice stated that "[e]ven if the individual mandate is 'necessary' to the Act's insurance reforms, such an expansion of federal power is not a 'proper' means for making those reforms effective." *Id.* at 558, 560.

All eight other Justices agreed with the basic principle that Congress believed that the individual mandate and the guaranteed-issue and community-rating reforms must operate together. *See NFIB*, 567 U.S. at 597-99, 619 (Ginsburg, J., concurring in part and dissenting in part); *id.* at 651, 685, 695-96 (joint dissent). As Justice Ginsburg put the point, "[w]ithout the individual mandate," as Congress learned from prior State experiences, "guaranteed-issue and community-rating requirements would trigger an adverse-selection death spiral in the health-insurance market: Insurance premiums would skyrocket, the number of uninsured would increase, and insurance companies would exit the market." *Id.* at 619.

The majority did not reach the issue of severability because it concluded that the individual mandate was a permissible exercise of the taxing power. The joint dissenters disagreed with that holding, and thus reached the severability question,

concluding that the remainder of the ACA was not severable and should be invalidated.

The joint dissent explained that the guaranteed-issue and community-rating provisions are inseverable from the individual mandate and are also integrally connected to other parts of the statute. The ACA was designed to "achieve near-universal health insurance coverage by spreading its costs to individuals, insurers, governments, hospitals, and employers—while, at the same time, offsetting significant portions of those costs with new benefits to each group." *NFIB*, 567 U.S. at 695 (joint dissent). This cost-shifting is achieved not only through the individual mandate and the guaranteed-issue and community-rating provisions, but also through an interlocking set of reimbursements, tax credits, and federal spending. *Id.* at 695-96. The joint dissent thus concluded that those provisions were not severable from the individual mandate and the Medicaid expansion (which was separately invalidated in part in *NFIB*). *See id.* at 697. The joint dissent then stated that the statute's remaining provisions would not operate in the manner Congress intended, would not have been enacted independently, or both. *Id.* at 705. The joint dissent thus would have struck down the statute in its entirety.

A few years later, in *King v. Burwell*, 135 S. Ct. 2480 (2015), the Court held that the ACA tax credits are available even in States that, rather than creating their own health-insurance exchanges, had allowed the federal government to create an exchange. The Court concluded that if tax credits were unavailable, the individual

mandate "would not apply in a meaningful way" because many individuals would become exempt from the mandate. *Id.* at 2493. The Court identified "three key reforms" that were part of the ACA: the individual mandate, the guaranteed-issue and community-rating provisions, and refundable tax credits that help make insurance more affordable. *Id.* at 2486-87. The Court noted that the "three reforms are closely intertwined," and, in particular, that "Congress found that the guaranteed issue and community rating requirements would not work without the coverage requirement." *Id.* at 2487.

3. The Tax Cuts and Jobs Act

As part of the TCJA, Congress amended 26 U.S.C. § 5000A(c) to eliminate, as of January 1, 2019, the shared responsibility payment for noncompliance with the "[r]equirement to maintain minimum essential coverage." Pub. L. No. 115-97, § 11081, 131 Stat. at 2092. The tax penalty for failing to maintain minimum essential coverage for tax years 2019 and beyond had previously been the greater of 2.5% of household income or $695. The TCJA reduced those figures to zero. *Id.*

The TCJA did not otherwise alter Section 5000A. The statute still says that persons subject to the individual mandate, known as "applicable individual[s]," "shall . . . ensure" that they are covered by "minimum essential coverage." 26 U.S.C. § 5000A(a). The statute still describes consequences for an applicable individual who "fails to meet the requirement" to maintain minimum essential coverage. *Id.*

§ 5000A(b). And Congress did not alter the title: "Requirement to maintain minimum essential coverage." *Id.* § 5000A.

Nor did the TCJA or any other statute amend Congress's prior findings regarding the centrality of the individual mandate to the ACA. For example, Congress has not repealed or amended its finding that, in a market with guaranteed-issue and community-rating provisions but not an individual mandate, "many individuals would wait to purchase health insurance until they needed care." 42 U.S.C. § 18091(2)(I). Nor has Congress repealed or amended its finding that the individual mandate "is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold." *Id.*

B. District Court Proceedings

Plaintiffs include Texas and several other States as well as two individuals challenging the constitutionality of the individual mandate and the enforceability of the ACA. The two individual plaintiffs—the only plaintiffs determined by the district court to have Article III standing—alleged that they are "subject to the individual mandate and object[] to being required by federal law to comply with it." ROA.507-508. They contended that, "[i]n the absence of the ACA," they "would purchase a health-insurance plan different from the ACA-compliant plans that they are currently required to purchase." ROA.529. Plaintiffs asserted that the Act's individual mandate

violated the U.S. Constitution and that the balance of the Act was not severable. *See* ROA.530-531.

California and several other States intervened in the proceedings as defendants for the purpose of arguing that the individual mandate is constitutional, and to assert that even if the individual mandate is unconstitutional, it is severable from the rest of the Act. ROA.946-952 (order granting intervention motion). The United States asserted in district court that the individual mandate is unconstitutional, and contended that the individual mandate cannot be severed from the guaranteed-issue and community-rating provisions, but argued that those three sets of provisions can be severed from the rest of the Act. ROA.1570.

The district court ruled that the individual plaintiffs had Article III standing, the individual mandate is unconstitutional, and the individual mandate is inseverable from the rest of the Act. The court found that the individual plaintiffs have standing because they "are the object of the Individual Mandate," which "requires them to purchase and maintain certain health-insurance coverage." ROA.2627. "[B]ecause the Individual Plaintiffs have standing," the district court stated, "the case-or-controversy requirement is met," and the court accordingly did not address whether the state plaintiffs had standing. ROA.2628-2629.

The court next held that the individual mandate, now that it no longer raises any revenue, is an unconstitutional exercise of Congress's authority. Under *NFIB*, the district court explained, the individual mandate was a proper exercise of Congress's

taxing power only because it "produce[d] at least some revenue for the government." ROA.2635 (quotation marks omitted). But "Section 5000A no longer contains an exaction" because Congress eliminated the shared responsibility payment. *Id.* The court concluded that, "[s]o long as the shared-responsibility payment is zero, the saving construction articulated in *NFIB* is inapplicable and the Individual Mandate cannot be upheld under Congress's Tax Power." ROA.2637.

The district court then addressed whether the individual mandate could be upheld as a valid exercise of Congress's authority to regulate interstate commerce. The court ruled that the individual mandate imposes a legal obligation on covered individuals to buy insurance, but explained that a majority of the Supreme Court had held in *NFIB* that such a mandate "could not pass muster under the Interstate Commerce Clause." ROA.2643-2644. The court found that the individual mandate "is no longer fairly readable as an exercise of Congress's Tax Power and continues to be unsustainable under Congress's Interstate Commerce Power." ROA.2644. It "therefore [found] the Individual Mandate, unmoored from a tax," to be "unconstitutional." *Id.*

The district court also examined whether the individual mandate is severable from some or all of the rest of the ACA. Citing *NFIB* and *King v. Burwell*, the court stated that "all nine Justices had agreed that *at least* the guaranteed-issue and community-rating provisions could not work without the Individual Mandate," and "all of them cited Congress's findings in reaching that conclusion." ROA.2654

(quotation marks omitted). Invoking the congressional factual findings, the court stated that "[t]he Individual Mandate is essential to the ACA, and that essentiality requires the mandate to work together with the Act's other provisions." ROA.2657 (emphasis omitted). And the court noted that, when Congress amended the ACA in 2017 and eliminated the shared responsibility payment, "it did not repeal the Individual Mandate" and "did not repeal" Congress's factual findings from 2010. ROA.2662-2663; *see* ROA.2664 ("The Court finds the 2017 Congress had no intent with respect to the Individual Mandate's severability."). For those reasons, the court found that "the Individual Mandate 'is essential to' and inseverable from 'the other provisions of' the ACA." ROA.2665.

On December 30, 2018, the district court entered partial final judgment pursuant to Federal Rule of Civil Procedure 54(b) on Count I of the amended complaint (which had sought a declaration that the individual mandate is unconstitutional and not severable from the remainder of the ACA), but stayed the judgment and stayed further district-court proceedings pending appellate proceedings in this Court. ROA.2755-2784, 2786. The Intervenor States and the United States both filed timely notices of appeal. ROA.2787-2792, 2844-2845. This Court granted permissive intervention to the U.S. House of Representatives. *See* Order (Feb. 14, 2019). The United States has since informed this Court that it now agrees with the district court's conclusion, and obtained leave to file this brief on the appellees' schedule (though the government formally remains an appellant, *see United States v.*

Windsor, 570 U.S. 744, 756-59 (2013)). *See* Letter re: United States brief (Mar. 25, 2019); Order (Apr. 8, 2019).

SUMMARY OF ARGUMENT

Plaintiffs have standing to challenge the numerous provisions of the ACA that work together to cause them cognizable injury. And on the merits, the district court correctly ruled that, in the absence of any revenue-raising provision, the individual mandate can no longer properly be upheld as a tax and is therefore unconstitutional. Under severability principles, in the absence of the mandate, Congress would not have intended to retain the guaranteed-issue and community-rating provisions, which Congress expressly found depended on the mandate, or the rest of the ACA, which involves numerous other interdependent provisions likewise designed to work together to expand health-insurance coverage and to shift healthcare costs. The district court thus properly concluded that the ACA is invalid in its entirety.

I. The ACA concretely injures the individual plaintiffs by requiring them to purchase health insurance, increasing their health-insurance costs, and limiting their health-insurance choices. The individual plaintiffs accordingly have standing to challenge the interrelated provisions of the ACA that work together to harm them, and the district court properly resolved both plaintiffs' challenge to the constitutionality of the individual mandate and their legal argument that the other injurious provisions are inseverable from the mandate because the entire ACA is inseverable from the mandate. Plaintiffs are not, however, entitled to seek or obtain

judicial relief against provisions of the ACA that do not in any way affect them. *See, e.g.*, *Printz v. United States*, 521 U.S. 898, 935 (1997) (explaining that the Court has "no business" addressing the validity of provisions that concern only "the rights and obligations of parties not before" it). Thus, although the district court and this Court have jurisdiction to address plaintiffs' challenges, and the district court correctly concluded that the ACA is invalid in its entirety, the relief awarded to plaintiffs should extend only to the ACA's provisions that actually injure them.

II. In *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012), the Supreme Court ruled that a mandate requiring individuals to buy health insurance would exceed Congress's powers under the Commerce and Necessary and Proper Clauses. Although the Court concluded that the individual mandate contained within the Affordable Care Act was most naturally read as such a mandate, the Court applied constitutional-avoidance principles and concluded that the mandate could also be construed as a proper exercise of Congress's power to lay and collect taxes. In so holding, the Court stressed that the penalty paid by covered individuals who fail to maintain minimum essential coverage had "the essential feature of any tax," that it "produces at least some revenue for the Government." *Id.* at 564.

As amended in 2017, the statute still "[r]equire[s]" individuals "to maintain minimum essential coverage." 26 U.S.C. § 5000A(a). But as of January 1, 2019, there is no monetary penalty for failing to comply with the individual mandate. Because the mandate no longer has the "essential feature" that it produces "at least some

revenue," the district court properly determined that the mandate is no longer sustainable as an exercise of Congress's taxing powers.

III. When a provision in a statute is held unconstitutional, other provisions may be upheld only if they are "(1) constitutionally valid, (2) capable of functioning independently, and (3) consistent with Congress' basic objectives in enacting the statute." *United States v. Booker*, 543 U.S. 220, 258-59 (2005) (citations and quotation marks omitted). A court must invalidate other provisions if it is "evident that Congress would not have enacted those provisions which are within its power, independently of those which are not." *Murphy v. NCAA*, 138 S. Ct. 1461, 1482 (2018) (brackets omitted). Under these principles, the remaining ACA provisions should not be severed from the individual mandate, regardless of whether the government might support some of those provisions as a policy matter.

As an initial matter, the guaranteed-issue and community-rating provisions cannot be severed from the individual mandate. When Congress enacted the ACA, it codified factual findings that the three sets of provisions must operate together. The Supreme Court has twice accepted that indication of legislative intent, drawing on Congress's concerns about the experience in States that had adopted forms of the guaranteed-issue and community-rating provisions without an individual mandate. When Congress in 2017 eliminated the mandate's penalty but left the mandate itself in place, it did not revise prior congressional findings that the mandate is "essential" to the operation of the guaranteed-issue and community-rating provisions. The

amended statute should not be construed to impliedly repeal those findings, and thus the individual mandate is inseverable from the guaranteed-issue and community-rating provisions under the scheme that Congress enacted.

Moreover, once those core provisions are excised, the balance of the ACA cannot continue to operate as intended. As the joint dissent in *NFIB* explained, the statute contains a complex web of "mandates and other requirements; comprehensive regulation and penalties; some undoubted taxes; and increases in some governmental expenditures, decreases in others." *NFIB*, 567 U.S. at 694. The desired interactions between these provisions cannot be achieved once the individual mandate and the guaranteed-issue and community-rating provisions are excised. Instead of rewriting the statute by picking and choosing which provisions to invalidate, the proper course is to strike it down in its entirety.

STANDARD OF REVIEW

This Court "review[s] a grant of summary judgment de novo." *Smith v. Regional Transit Auth.*, 827 F.3d 412, 417 (5th Cir. 2016).

ARGUMENT

I. The Individual Plaintiffs Have Standing To Challenge The Individual Mandate And Other Provisions Of The ACA That Injure Them

A. The ACA injures the individual plaintiffs by requiring them to purchase health insurance, increasing their health-insurance costs, and limiting their health-insurance choices

To satisfy Article III's standing requirement, a plaintiff must establish that it has suffered a "concrete and particularized" injury that is "actual or imminent"; that that the injury is "fairly traceable" to the alleged violation; and that the injury would "likely" be "redressed" by a favorable decision. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992) (alterations omitted). Because "[s]tanding is not dispensed in gross," "a plaintiff must demonstrate standing for each claim he seeks to press . . . [and] each form of relief." *Davis v. FEC*, 554 U.S. 724, 733-34 (2008) (quotation marks omitted). But if "at least one" plaintiff has standing to seek particular relief, the court "need not consider" whether other plaintiffs do too. *Horne v. Flores*, 557 U.S. 433, 446 (2009). Here, the individual plaintiffs have standing to challenge the constitutionality of the individual mandate and to argue that other provisions of the ACA are not severable.

To begin, the individual plaintiffs are directly subject to the individual mandate and have established concrete financial injuries from it. In particular, they filed declarations stating that they would prefer not to maintain minimal essential health coverage as the ACA defines that term, but have maintained such coverage only

because the ACA imposes a legal obligation to do so. *See* ROA.637, 641. The intervenor-appellants argue that this alleged injury is not caused by the mandate and is instead self-inflicted, reasoning that, even after the TCJA, the mandate still grants the individual plaintiffs the voluntary choice of whether to purchase ACA-compliant insurance or instead pay a tax (now, $0). House Br. 21-23; Cal. Br. 25-26. But as intervenors themselves acknowledge, that standing objection is substantively the same as their merits defense of the mandate and thus adds nothing to their position.

The House further argues (Br. 24-28) that, even if the post-TCJA mandate now imposes a binding legal duty, the individual plaintiffs still will not suffer a cognizable Article III injury because there is no longer any means of enforcing the mandate and thus they can violate it with impunity. This Court need not decide the difficult question whether a plaintiff who is directly subjected to a legal obligation must additionally face a credible threat of enforcement to obtain judicial review. Even if a plaintiff could not sue if his *only* injury was being subjected to an unenforceable mandate, the individual plaintiffs here have an *additional* injury related to the mandate that is the subject of federal ACA enforcement.

Namely, the ACA's insurance-reform provisions, which the individual plaintiffs claim are inseverable from the mandate, also impose concrete financial injuries on them. In particular, numerous provisions of the ACA operate to increase the cost of insurance for individuals like plaintiffs, and to decrease their options in selecting health insurance. The individual plaintiffs' declarations explain that they are self-

employed individuals who are especially burdened by the ACA and are ineligible for subsidies to purchase health insurance. *See* ROA.636, 640. One plaintiff, the founder of a management consulting business, is "young and in good health," has no dependents, and would prefer to obtain a high-deductible plan priced according to his actuarial risks—an option not available to him under the ACA. ROA.636-637. The other is the owner of a consulting business and is married with two dependent children. ROA.640. As the result of the ACA, his monthly premiums have increased dramatically, he has been unable to obtain a plan that would accept all of his family's health providers, and the quality of services from providers that accept his family's new plan is lower than before. *Id.*

These increased costs and decreased options are attributable to challenged provisions of the ACA. The guaranteed-issue and community-rating provisions, 42 U.S.C. §§ 300gg-1, 300gg-3, limit the ability of insurance companies to change their prices based on the health of the insured, thus increasing costs for relatively young and healthy individuals. And the coverage requirements and essential benefits packages, *id.* §§ 300gg-11, 300gg-14(a)), 18022, limit choices in the insurance markets that both plaintiffs would prefer. Thus, the individual plaintiffs have asserted concrete financial and practical injuries caused by the ACA's provisions, which operate together to limit their insurance options.

The House contends (Br. 34) that the individual plaintiffs cannot challenge the ACA's injurious insurance reforms on the grounds that they are inseverable from the

unconstitutional individual mandate, unless those plaintiffs have standing to challenge the mandate in isolation. But this is not a case like *National Federation of the Blind of Texas, Inc. v. Abbott,* 647 F.3d 202 (5th Cir. 2011), where the plaintiffs sought to challenge the constitutionality of a provision that *did not actually apply to them* merely because it was allegedly inseverable from the provision that did apply to them. *See id.* at 209-11. Indeed, that case is especially inapposite because the provision that did apply to the plaintiffs was itself unconstitutional, and thus it was *entirely unnecessary* to consider either the constitutionality or the severability of the provision that did not apply to plaintiffs in order to provide them complete relief from the provision that actually injured them. *See id.* at 215-16; *see also infra* Part I.B.

In sum, assuming the individual plaintiffs here are correct on the merits, they are directly subject *both* to the ACA's mandate that unconstitutionally compels them to purchase insurance they do not want and *also* to the ACA's inseverable insurance reforms that increase the costs and decrease the options of the insurance they can choose to buy. There is no basis for preventing the individual plaintiffs from seeking judicial relief from these concrete financial injuries caused by the law enforced by the Federal Defendants, merely because the insurance reforms are inseverable rather than unconstitutional and the mandate is unenforceable in addition to unconstitutional. A declaratory judgment that the mandate is unconstitutional (because it now imposes a binding legal duty to purchase compliant health insurance) and that the ACA's insurance reforms are inseverable from the mandate (because the entire ACA is

inseverable from the mandate) would undoubtedly redress the individual plaintiffs' injuries from the ACA—that is sufficient to establish their standing to raise those claims on the merits.[2]

B. The individual plaintiffs' standing extends only to those ACA provisions that operate together to injure them

Because the individual plaintiffs have standing to challenge the ACA's injurious insurance reforms, they can raise the merits argument that those provisions are inseverable on the ground that the entire ACA is inseverable from the individual mandate and the guaranteed-issue and community-rating provisions. But while that argument, if successful, means that the entire ACA is invalid, plaintiffs do not have standing to seek relief against provisions of the ACA that do not in any way affect them.

In general, courts "have no business answering" questions about the validity of provisions that concern only "the rights and obligations of parties not before the Court." *Printz v. United States*, 521 U.S. 898, 935 (1997); *see also Murphy v. NCAA*, 138 S. Ct. 1461, 1485-87 (2018) (Thomas, J., concurring). That principle is consistent with basic limitations on Article III standing. *E.g.*, *Town of Chester v. Laroe Estates, Inc.*, 137 S. Ct. 1645, 1650 (2017) ("[A] plaintiff must demonstrate standing . . . for each form

[2] For the same reasons, the individual plaintiffs would have standing to obtain an injunction against enforcement with respect to them of the ACA's injurious insurance reforms, and thus the district court had authority instead to enter a declaratory judgment. *Cf.* Br. of Amici Curiae Samuel L. Bray et al. 4.

of relief that is sought."); *Gill v. Whitford*, 138 S. Ct. 1916, 1934 (2018) ("[S]tanding is not dispensed in gross: A plaintiff's remedy must be tailored to redress the plaintiff's particular injury.") (quotation marks omitted); *Legacy Cmty. Health Servs., Inc. v. Smith*, 881 F.3d 358, 366 (5th Cir.) (healthcare provider "must show standing to challenge each alleged deficiency in Texas's remedial scheme," but could only do so for certain provisions), *cert. denied*, 139 S. Ct. 211 (2018). And restraints on equitable remedies dictate the same result. *See, e.g.*, *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979) (explaining that "injunctive relief should be no more burdensome to the defendant than necessary to provide complete relief to the plaintiffs"); *OCA-Greater Hous. v. Texas*, 867 F.3d 604, 616 & nn.49-50 (5th Cir. 2017) (vacating injunction prohibiting Texas from enforcing provisions of its election code to the extent they are inconsistent with federal law because the injunction exceeded the scope of plaintiff's harm).

In *Printz*, for example, the Supreme Court rejected a request that it decide the severability of provisions of the Brady Handgun Violence Prevention Act that did not burden the parties to the litigation. Even though the Court held unconstitutional the provisions requiring local law enforcement officers to conduct background checks of prospective gun buyers, it refused to address the severability of provisions requiring firearms dealers to notify law enforcement officers of purchases and wait five days before completing the sale. 521 U.S. at 935. The waiting-period provisions "burden[ed] only firearms dealers and purchasers, and no plaintiff in either of those

categories" was before the Court. *Id.* On the other hand, the Supreme Court noted that it has addressed the severability of other provisions where they actually "affected the plaintiffs." *Id.* (characterizing *New York v. United States*, 505 U.S. 144 (1992)).

This Court adopted a similar approach in *National Federation of the Blind*, discussed above. While the plaintiffs there had standing to challenge the statutory provision that injured them, they were not entitled to challenge other provisions that did not apply to them or in any way harm them, even if those provisions might have been inseverable from the unconstitutional provision that did directly regulate and injure them. 647 F.3d at 209-11.

Accordingly, while the district court properly considered the legal issues before it and this Court has jurisdiction to affirm the reasoning below on the merits, the relief awarded should be limited only to those provisions that actually injure the individual plaintiffs. For example, the ACA amended several criminal statutes used to prosecute individuals who defraud our healthcare systems. *See, e.g.*, 18 U.S.C. § 1347(b) & 42 U.S.C. § 1320a-7b(h) (defining scienter required for healthcare fraud and anti-kickback violations); 29 U.S.C. § 1149 (adding a false statement offense relating to the sale and marketing of employee health benefit plans). It is unlikely that the plaintiffs here would have standing to challenge the validity of those statutes. *See Linda R.S. v. Richard D.*, 410 U.S. 614, 619 (1973) ("[I]n American jurisprudence at least, a private citizen lacks a judicially cognizable interest in the prosecution or

nonprosecution of another."). The district court can determine the precise scope of the judgment on remand.

II. The Individual Mandate Is Unconstitutional Because Congress Eliminated The Tax Penalty On Which The Supreme Court's Savings Construction Rested

A. In *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012), the Supreme Court ruled that the individual mandate cannot be sustained under the Commerce and Necessary and Proper Clauses as a command requiring "individuals to buy" health insurance. *Id.* at 560-62 (controlling opinion of Roberts, C.J.); *see also id.* at 649-61 (joint dissent agreeing with this proposition); *id.* at 570 (opinion of the Court acknowledging the constitutional holding). The Chief Justice's controlling opinion stated that the individual mandate would be most naturally read as such an unconstitutional mandate, *id.* at 562 (opinion of Roberts, C.J.), but the Court applied principles of constitutional avoidance to construe the statute as a valid exercise of Congress's power to lay and collect taxes, *id.* at 564 (opinion of the Court). In particular, the Court emphasized that the tax penalty paid by individuals who fail to maintain minimum essential coverage "produces at least some revenue for the Government." *Id.*; *see* ROA.2633 (district court opinion) ("Put plainly, because Congress had the power to enact the shared-responsibility exaction, § 5000A(b), under the Tax Power, it was fairly possible to read the Individual Mandate, § 5000A(a), as a functional part of that tax also enacted under Congress's Tax Power.

Therefore, § 5000A *as a whole* could be viewed as an exercise of Congress's Tax Power.").

As amended, the individual mandate preserves the "[r]equirement to maintain minimum essential coverage." 26 U.S.C. § 5000A. It specifies that covered individuals "shall . . . ensure" that they obtain "minimum essential coverage." *Id.* § 5000A(a). That is a legal command. *See NFIB*, 567 U.S. at 562 (opinion of Roberts, C.J.) ("The most straightforward reading of the mandate is that it commands individuals to purchase insurance. After all, it states that individuals 'shall' maintain health insurance."); *see id.* at 574 ("the statute reads more naturally as a command to buy insurance than as a tax"). As the district court explained, "the fact that many individuals will no longer feel bound by the Individual Mandate does not change either that some individuals will feel so bound—such as the Individual Plaintiffs here—or that the Individual Mandate is still law." ROA.2640.

But there is no longer a tax penalty; the monetary penalty for failing to comply with that requirement is now $0. 26 U.S.C. § 5000A(c); *see* ROA.2635 ("Section 5000A no longer contains an exaction."). Thus, while the Supreme Court previously adopted a saving construction that construed the statute as allowing covered individuals to choose between buying health insurance and paying a tax, now there is no choice because there is no tax to pay.

As a result, it is no longer "fairly possible" to interpret the mandate as a tax. *NFIB*, 567 U.S. at 563 (opinion of Roberts, C.J.). The mandate no longer "yields the

essential feature of any tax," which is that it must "produce[] at least some revenue for the Government." *Id.* at 564 (opinion of the Court); *see id.* at 574 ("Congress's authority under the taxing power is limited to requiring an individual to pay money into the Federal Treasury, no more."). Instead, as its text indicates, the mandate operates as a bare "[r]equirement" that individuals "shall . . . ensure" that they obtain health insurance of the type that Congress prescribed. 26 U.S.C. § 5000A(a).

That plain-text interpretation is confirmed by the "cardinal principle" that a statute should be construed so that "no clause, sentence, or word shall be superfluous, void, or insignificant." *TRW Inc. v. Andrews*, 534 U.S. 19, 31 (2001). Because Section 5000A(b) no longer imposes a monetary penalty, Section 5000A(a)'s references to the "[r]equirement to maintain minimum essential coverage" and its command that covered individuals "shall" maintain insurance would be meaningless if they did not operate as legal obligations to maintain insurance. Section 5000A(d)'s exemption from that requirement would likewise be inoperative. *See* 26 U.S.C. § 5000A(d) (setting forth certain categories of individuals who are not subject to Section 5000A(a)'s "[r]equirement to maintain minimum essential coverage").

But so long as it remains in effect, the individual mandate violates the Supreme Court's directive in *NFIB* that individuals cannot be forced into commerce through an obligation to purchase health insurance. *NFIB*, 567 U.S. at 575 (opinion of Roberts, C.J.) ("The Federal Government does not have the power to order people to buy health insurance."); *see id.* at 706-07 (joint dissent). Because the individual

mandate operates as a command but no longer functions as a tax, it exceeds Congress's enumerated powers. *See* ROA.2637 ("So long as the shared-responsibility payment is zero, the saving construction articulated in *NFIB* is inapplicable and the Individual Mandate cannot be upheld under Congress's Tax Power.").

This Court's decision in *United States v. Ardoin*, 19 F.3d 177 (5th Cir. 1994), does not compel a contrary result. There, this Court considered the unusual situation in which Congress had imposed a $200 tax on machineguns, but subsequently outlawed machineguns altogether and instructed the relevant agency to stop collecting the tax. The defendant was convicted for failing to pay the tax, which remained on the books. This Court upheld the conviction, holding that the tax law at issue could "be upheld on the preserved, but unused, power to tax or on the power to regulate interstate commerce." *Id.* at 180. Thus, in *Ardoin*, the defendant was responsible for a tax payment of $200, and non-collection of the tax did not negate the existence of the tax or the formal obligation to pay it. Here, by contrast, there is no tax liability at all. Moreover, the conduct at issue in *Ardoin* could have been regulated under Congress's power to regulate interstate commerce (and, indeed, was so regulated, *see* 18 U.S.C. § 922(o)); *Ardoin* thus does not stand for the proposition that Congress can prohibit conduct that exceeds its commerce power through a two-step process of first taxing it and then eliminating the tax while retaining the prohibition.

B. The intervenor-appellants make a scattershot of counter-arguments to the foregoing analysis. They fail to persuade, individually or collectively.

The intervenors principally contend that the mandate remains a valid exercise of the taxing power. Their main rationale is that the statute purportedly "continues to offer individuals a choice" either "to maintain insurance coverage" or "not to do so and instead face the tax consequences that Section 5000A prescribes," which "shall now be nothing." House Br. 35; *see also* Cal. Br. 28 ("individuals may freely choose between having health insurance and not having health insurance"). That, however, is not a tenable reading of the mandate as amended: The statute still expressly provides that individuals "shall . . . ensure" that they have health insurance, 26 U.S.C. § 5000A(a), and "[t]he most straightforward reading" of that language is still that "it commands individuals to purchase insurance," *NFIB*, 567 U.S. at 562 (opinion of Roberts, C.J.). Yet it no longer is "fairly possible" (*id.* at 563) to adopt the savings construction that the statute merely provides a choice between purchasing insurance and paying a tax, as the statute no longer "yields the essential feature of any tax" to "produce[] at least some revenue for the Government," *id.* at 564 (opinion of the Court). And for the same reason, the intervenors err in suggesting (House Br. 16; Cal. Br. 29) that Congress did not speak clearly enough to undo the savings construction adopted in *NFIB*; to the contrary, Congress removed the linchpin of the Court's interpretation.

California fails to advance its tax-power argument by analogizing (Br. 31-32) the individual mandate shorn of its penalty to taxes with effective dates that have been delayed or suspended, or to taxes that are likely to collect little or no revenue because

they effectively discourage the taxed activity. Those taxes merely will not raise revenues at particular times, but the mandate as amended will never raise any revenue. Likewise, the House gains nothing by observing (Br. 19) that *NFIB* held the mandate to be a tax even though some individuals were subject to the mandate but exempt from its penalty. As the House itself emphasizes (Br. 18), a savings construction "controls as to *all* applications of [a] statute," and it was fairly possible at the time of *NFIB* to construe the statute as imposing a tax choice rather than a legal duty because most Americans subject to the mandate were also subject to its penalty. *See* 26 U.S.C. § 5000A(d)-(e). That, however, is no longer the case.

The House also errs in its fallback argument (Br. 39) that the mandate is at least necessary and proper to Congress's exercise of the taxing power because it retains "the existing statutory structure" so that Congress could "later reinstate a higher payment." It is, instead, gratuitous and inappropriate to leave on the books an unconditional mandate that violates *NFIB*—let alone to do that merely so Congress hypothetically could reinstate a tax by again amending the amount of the mandate's penalty instead of simply drafting language that gives individuals a choice rather than a duty.

Shifting gears from their reliance on the tax power, the intervenors argue that the amended mandate should be construed as equivalent to a "simply precatory" "'sense of the Congress' resolution[]." Cal. Br. 28; *see also* House Br. 36-37. But Congress mandated that individuals "shall" take an action, not that they "should" do

so or that Congress has a subjective preference for that action. Neither California nor the House identifies any other provision of federal law that commands without qualification or condition that individuals "shall" take an action, but nonetheless "does not affect legal rights and duties," House Br. 38. And neither governmental entity explains why this Court should hold that law-abiding citizens can simply ignore a legislative mandate to engage in certain conduct merely because the mandate lacks an enforcement mechanism.

Finally, the House briefly suggests (Br. 40) that, even if the statute as amended does impose a legally binding obligation to purchase insurance, it would be necessary and proper to the exercise of Congress's commerce power, notwithstanding *NFIB*'s square holding to the contrary, merely because the mandate now lacks a coercive penalty. But this purported distinction of *NFIB* is illusory. The Chief Justice explained in *NFIB* that the mandate could not be upheld under the Necessary and Proper Clause because Congress had no authority to expand federal power by compelling people to purchase health insurance—a conclusion that did not depend on the size of the sanction imposed for noncompliance with the mandate. *See NFIB*, 567 U.S. at 560; *see also id.* at 654-55 (joint dissent). Thus, Congress cannot impose a mandate to purchase health insurance even though it has eliminated the monetary penalty, any more than Congress could have retained the legal prohibition on possessing a firearm in a school zone, notwithstanding *United States v. Lopez*, 514 U.S. 549 (1995), merely by eliminating the criminal penalty imposed.

III. The Individual Mandate Is Not Severable From The Guaranteed-Issue And Community-Rating Provisions, And The Rest Of The ACA Is Not Severable In Turn

The test for severability is "essentially an inquiry into legislative intent." *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999). That inquiry requires an analysis of the relationship between the unconstitutional provision and the remaining provisions of the statute. Other provisions may be severed from the unconstitutional provision only if they are "(1) constitutionally valid, (2) capable of functioning independently, and (3) consistent with Congress' basic objectives in enacting the statute." *United States v. Booker*, 543 U.S. 220, 258-59 (2005) (citations and quotation marks omitted). By contrast, other provisions are inseverable if it is "evident that Congress would not have enacted those provisions which are within its power, independently of those which are not." *Murphy v. NCAA*, 138 S. Ct. 1461, 1482 (2018) (brackets omitted).

A court's fundamental task is to ask "which alternative adheres more closely to Congress' original objective." *Booker*, 543 U.S. at 263. Accordingly, while the "normal rule is that partial, rather than facial, invalidation is the required course," *Free Enter. Fund v. Public Co. Accounting Oversight Bd.*, 561 U.S. 477, 508 (2010) (quotation marks omitted), courts must deem provisions inseverable if their continued enforcement would result in "a scheme sharply different from what Congress contemplated," and courts also "cannot rewrite a statute and give it an effect

altogether different from that sought by the measure viewed as a whole," *Murphy*, 138 S. Ct. at 1482.

A. The individual mandate is inseverable from the guaranteed-issue and community-rating provisions

The guaranteed-issue and community-rating provisions should not be severed from the individual mandate. Even though these provisions are "constitutionally valid" when standing on their own—and even though the government supports them as a policy matter—it is "evident" that Congress would not have adopted them absent the individual mandate. *See Murphy*, 138 S. Ct. at 1482.

Congress expressly found that the individual mandate is essential to the operation of the guaranteed-issue and community-rating provisions. "[I]f there were no requirement" to purchase insurance, Congress's codified factual findings concluded, "many individuals would wait to purchase health insurance until they needed care." 42 U.S.C. § 18091(2)(I); *see* ROA.2648 ("Those findings are not mere legislative history—they are enacted text that underwent the Constitution's requirements of bicameralism and presentment; agreed to by both houses of Congress and signed into law by President Obama."). But "[b]y significantly increasing health insurance coverage," the mandate, "together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums." 42 U.S.C. § 18091(2)(I). For that reason, Congress concluded, the individual mandate is

"*essential* to creating effective health insurance markets in which improved health insurance products that are *guaranteed issue and do not exclude coverage of pre-existing conditions* can be sold." *Id.* (emphases added); *see id.* § 18091(2)(J) ("The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.").

In expressly finding a necessary link between those three sets of provisions, Congress looked to experiences from prior state experiments in restructuring their laws governing health insurance. Congress was well aware, in particular, that in some States, guaranteed-issue and community-rating requirements "had an unintended consequence: They encouraged people to wait until they got sick to buy insurance." *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). The "adverse selection" of disproportionately ill people purchasing insurance forced insurers to raise premiums, with the consequence that, "[a]s the cost of insurance rose, even more people waited until they became ill to buy it." *Id.* at 2485-86. Congress was concerned about the resulting "economic 'death spiral,'" and thus looked to the experience of Massachusetts, which paired guaranteed-issue and community-rating requirements with tax credits and a requirement to purchase health insurance. *Id.* at 2486; *see* 42 U.S.C. § 18091(2)(D) ("The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement

has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.").

Accordingly, in *NFIB*, all nine Justices agreed that the individual mandate, the guaranteed-issue provisions, and the community-rating provisions were necessarily intertwined—and that Congress viewed them as such. *See* 567 U.S. at 548 (opinion of Roberts, C.J.) ("The guaranteed-issue and community-rating reforms . . . exacerbate" the "problem" of "healthy individuals who choose not to purchase insurance to cover potential health care needs," and "threaten to impose massive new costs on insurers. . . . The individual mandate was Congress's solution to these problems."); *id.* at 597-98 (Ginsburg, J., concurring in part and dissenting in part) ("[T]hese two provisions, Congress comprehended, could not work effectively unless individuals were given a powerful incentive to obtain insurance. . . . *[G]uaranteed-issue and community-rating laws alone will not work*." (emphasis added)); *id.* at 599 (noting that Congress "coupl[ed] the minimum coverage provision with guaranteed-issue and community-rating prescriptions"); *id.* at 695-96 (joint dissent) ("Insurance companies bear new costs imposed by a collection of insurance regulations and taxes, including 'guaranteed issue' and 'community rating' requirements . . . but the insurers benefit from the new, healthy purchasers who are forced by the Individual Mandate to buy the insurers' product."). As the district court explained, "the Government and all nine Justices . . . agreed that at least the guaranteed-issue and community-rating provisions could not work without the Individual Mandate." ROA.2654 (quotation marks and

emphasis omitted). And in *King*, the Court similarly acknowledged both that the "reforms are closely intertwined" and that "Congress found that the guaranteed issue and community rating requirements would not work without the coverage requirement." 135 S. Ct. at 2487.

In 2017, Congress eliminated the mandate's tax penalty, but did not eliminate the mandate itself that individuals shall be required to purchase health insurance. That change does not alter what Congress in its prior findings and the Supreme Court in *NFIB* and *King* had expressly concluded: that the individual mandate, guaranteed-issue, and community-rating provisions operate as mutually reinforcing provisions dependent on one another. The Supreme Court recently concluded that when provisions "were obviously meant to work together," and some of them are struck down as unconstitutional, the other provisions should also be invalidated because Congress would not "have wanted [them] to stand alone." *Murphy*, 138 S. Ct. at 1483. Here, Congress did not want the guaranteed-issue and community-rating provisions to stand alone.

The intervenors argue that Congress necessarily intended for the guaranteed-issue and community-rating provisions to remain even if the mandate were invalidated, because Congress left the former provisions (and the rest of the ACA) intact despite itself eliminating the mandate's penalty. *See* House Br. 43-44; Cal. Br. 34-35. But this argument overlooks that Congress did *not* eliminate the mandate: It left on the books a "requirement" that individuals "shall" purchase health insurance,

26 U.S.C. § 5000A, and the subsequent judicial invalidation of that requirement is what gives rise to the inseverability question here. Although the intervenors further argue that Congress would no longer have cared if the mandate itself were formally invalidated because the mandate without a penalty purportedly would not have much practical effect, *see* House Br. 45; Cal. Br. 44, Congress retained the provision and intervenors provide no evidence that Congress as a whole shared their pessimistic view that most American citizens would flout a mandatory requirement to purchase insurance simply because that legal duty is not backed by an enforcement penalty.

To the contrary, Congress has never amended or repealed its findings that the individual mandate is "essential to creating effective health insurance markets." 42 U.S.C. § 18091(2)(I). Concluding that Congress had somehow implicitly altered its view that the individual mandate is essential to the guaranteed-issue and community-rating provisions would be akin to finding a repeal by implication. But repeals by implication "are disfavored and will not be presumed unless the legislature's intent is clear and manifest." *In re Lively*, 717 F.3d 406, 410 (5th Cir. 2013) (quotation marks omitted). Congress as a whole has nowhere demonstrated an intent, let alone a clear and manifest intent, to overturn its prior findings that the individual mandate, the guaranteed-issue provisions, and the community-rating provisions must operate together. This Court should refrain from interpreting the revised statute to be at war with congressional findings that expressly link the individual mandate to the other health-insurance reforms.

The House tries to minimize the import of the statutory findings by suggesting that Congress was concerned only about "*creating* effective health insurance markets," and thus would not have thought it necessary to require individuals to renew their coverage "now that insurance marketplaces are fully up and running." House Br. 52; *see also* Cal. Br. 45 (arguing that experience has shown that the mandate is not essential to the operation of the insurance marketplaces). But that position cannot be reconciled with either the statutory findings or the mandate itself. Nothing in the findings supports the assertion that Congress thought that the mandate was necessary to force unwilling customers into the new insurance marketplaces in the first place, but was not necessary to keep such customers in the marketplaces once they were established. And that assertion is belied by the fact that Congress originally structured the mandate's penalty *to increase* over time. *See* 26 U.S.C. § 5000A(c)(2)(B), (3)(A)-(B) (2010-2017 version), *reprinted in* House Br. A-9 to A-10.

Finally, California mistakenly suggests (Br. 40-41) that a proper remedy might be to reinstate the tax that Congress deliberately set to zero. As the district court explained, "[t]he unconstitutional act in this case is the Individual Mandate, not the TJCA." ROA.2664 n.34. Thus, the Supreme Court's decision in *Frost v. Corporate Commission of Oklahoma*, 278 U.S. 515 (1929), is inapposite: There, as the district court explained, an amendment did not "render[] the original statute unconstitutional," but rather was "unconstitutional itself" under the Equal Protection Clause. ROA.2664 n.34. Here, by contrast, the repeal of the tax is not itself unconstitutional. Thus, the

focus is not exclusively on the 2010 Congress or the 2017 Congress, as the current statutory scheme is the product of enactments by both bodies. The relevant point is that Congress sought to impose a mandate without collecting any tax, and that unconstitutional provision is intertwined with the operation of the guaranteed-issue and community-rating provisions, as both Congress and the Supreme Court have found.

B. The rest of the ACA's provisions are inseverable

Once the individual mandate and the guaranteed-issue and community-rating provisions are invalidated, the remaining provisions of the ACA should not be allowed to remain in effect—again, even if the government might support some individual provisions as a policy matter. As explained by the joint dissenters in *NFIB*—the only Justices to reach the severability issue—without those core provisions, the ACA's interlocking web of provisions cannot function as Congress intended. Again, as the Supreme Court recently recognized when addressing a set of provisions that "were obviously meant to work together," once the core provisions are struck down the others should also be invalidated if Congress would not "have wanted [them] to stand alone." *Murphy*, 138 S. Ct. at 1483.

Elimination of the guaranteed-issue and community-rating provisions would fundamentally alter the ACA's other insurance reforms, which were premised on the availability of uniform plans to all potential purchasers of insurance in the individual and small-group markets. The Supreme Court has already acknowledged that the

various other reforms were linked to the guaranteed-issue and community-rating provisions. In *King*, the Court rejected the suggestion that Congress might have wanted to allow the guaranteed-issue and community-rating requirements to apply without the individual mandate and the tax credits. 135 S. Ct. at 2494. Citing the joint dissent in *NFIB*, the Court deemed it "implausible that Congress meant the Act to operate in this manner." *Id.*

It is similarly implausible that Congress meant for subsets of its insurance reforms to take effect, without the others with which they were intended to work in concert. The problem is more fundamental than the hypothetical inquiry into congressional intent that typifies severability analysis. The problem is that as a substantive matter, once the guaranteed-issue and community-rating provisions are eliminated, the remaining insurance reforms would operate in a materially different way from the way that Congress intended. As even the amicus curiae appointed in *NFIB* to argue in *favor* of severability acknowledged, "the effects of invalidating the guaranteed issue and community rating provisions could not easily be limited to just those provisions." Br. for Court-Appointed Amicus Curiae Supporting Complete Severability, *NFIB*, at 46 (2012 WL 588458). Allowing some of the reforms to go into effect without others with which they are inextricably linked would not be giving effect to the statute but rewriting it, which is the prerogative of Congress rather than the courts.

For example, the ACA created insurance "exchanges" where individuals could purchase insurance. "A key purpose of an exchange is to provide a marketplace of insurance options where prices are standardized regardless of the buyer's pre-existing conditions," which allows a buyer to "compare benefits and prices." *NFIB*, 567 U.S. at 702 (joint dissent). Without the community-rating provision, which generally prohibits altering the price of insurance based on the buyer's health condition, "[t]he prices would vary from person to person," and "the exchanges cannot operate in the manner Congress intended." *Id.* at 702-03. And without the insurance exchanges, there would be no basis for requiring employers to make a payment to the federal government if they do not offer insurance to employees and those employees then purchase insurance on the exchange. *See* 26 U.S.C. § 4980H; *NFIB*, 567 U.S. at 703 (joint dissent).

The ACA's tax credits are likewise premised on the community-rating provisions. "Without the community-rating insurance regulation, . . . the average federal subsidy could be much higher; for community rating greatly lowers the enormous premiums unhealthy individuals would otherwise pay." *NFIB*, 567 U.S. at 701 (joint dissent). "The result would be an unintended boon to insurance companies, an unintended harm to the federal fisc, and a corresponding breakdown of the 'shared responsibility' between the industry and the federal budget that Congress intended." *Id.* at 702.

Similarly, the ACA included a panoply of other insurance regulations and taxes, such as coverage limits, requirements to cover dependent children, and restrictions on high-cost insurance plans. *See NFIB*, 567 U.S. at 698 (joint dissent) (citing 26 U.S.C. § 4980I; 42 U.S.C. §§ 300gg-11, 300gg-14(a)). These regulations all indisputably impose "higher costs for insurance companies." *Id.* The ACA's design contemplated that these costs would be offset by the individual mandate, which would increase the number of individuals enrolled in insurance, and by federal subsidies (as well as by the ACA's expansion of Medicaid, which was already partially invalidated in *NFIB*). *See id.* at 698-99. Allowing these provisions to continue in effect without the interdependent provisions already discussed would create an insurance market quite unlike the one that Congress intended, with potentially serious consequences for the stability of the market. *Id.* at 699.

As the joint dissent also explained, the ACA's cost-saving measures are linked to provisions that reduce uncompensated care. The ACA "reduces payments by the Federal Government to hospitals by more than $200 billion over 10 years." *NFIB*, 567 U.S. at 699 (joint dissent). These reductions are palatable only because other provisions of the ACA, discussed above, were expected to lead to "[n]ear-universal coverage" that would "offset the government's reductions in Medicare and Medicaid reimbursements to hospitals." *Id.* There is no indication that Congress would have cut payments without providing hospitals with an opportunity to receive offsetting revenue, and doing so could have dramatic effects unintended by Congress: "Some

hospitals may be forced to raise the cost of care in order to offset the reductions in reimbursements, which could raise the cost of insurance premiums, in contravention of the Act's goal of 'lower[ing] health insurance premiums.'" *Id.* (quoting 42 U.S.C. § 18091(2)(F)).

And these reductions in federal payments were in turn designed to "offset the $434-billion cost of the Medicaid Expansion." *NFIB*, 567 U.S. at 700 (joint dissent). "Congress chose to offset new federal expenditures with budget cuts and tax increases," *id.*, and there is no indication that Congress would have enacted a bill that greatly increased the federal deficit if the reductions in federal spending were invalidated. There is no tension between this conclusion and the majority's conclusion in *NFIB* that the Medicaid expansion should be allowed to take effect even if it could not be a condition on the remainder of a State's Medicaid allotment, *see* House Br. 54-55 (citing *NFIB*, 567 U.S. at 587). A less extensive expansion of Medicaid than Congress intended does not contravene Congress's objectives in the same way as a rebalancing of costs and benefits occasioned by eliminating the ACA's core insurance reforms and cost-cutting measures but retaining a large increase in federal expenditures.

That leaves the ACA's comparatively "minor," ancillary provisions. *See NFIB*, 567 U.S. at 704 (joint dissent). Some of those provisions interact with the major provisions just discussed, and thus would not act in the manner that Congress intended once the major provisions are invalidated. *See id.* at 705 (discussing tax

increases that offset costs imposed by health-insurance reforms). There are other provisions that might be able to operate in the manner that Congress intended when viewed in isolation, but the question of congressional intent as to those provisions is complicated by the circumstances surrounding their enactment. In previous severability cases, courts have examined related provisions to analyze their relationship, but neither this Court nor the Supreme Court (other than in *NFIB* itself) has "previously had occasion to consider severability in the context of an omnibus enactment like the ACA, which includes not only many provisions that are ancillary to its central provisions but also many that are entirely unrelated." *Id.* at 705.

In this unique context, comparatively "minor," ancillary provisions that were tacked on to the bill should be invalidated once the core provisions have been struck down because "[t]here is no reason to believe that Congress would have enacted them independently." *NFIB*, 567 U.S. at 705 (joint dissent). Those provisions were attached to the ACA for various reasons, potentially "because it was a quick way to get them passed despite opposition, or because their proponents could exact their enactment as the *quid pro quo* for their needed support." *Id.* As the joint dissent explained, when a court is "confronted with such a so-called 'Christmas tree,' a law to which many nongermane ornaments have been attached, . . . the proper rule must be that when the tree no longer exists the ornaments are superfluous." *Id.*

California's emphasis on the "far-reaching consequences that would result from making major changes to the ACA," Cal. Br. 36, merely underscores the dangers of

crafting a judicial remedy that picks and chooses among the provisions that Congress enacted to work together in this highly complex area. Rather than having a court select which provisions should remain in force—and thus, select winners and losers in the insurance markets and other spheres—that task should be left to Congress.

Finally, although the intervenors point out that Congress repeatedly declined to repeal additional provisions of the ACA before eliminating the mandate's penalty, House Br. 46; Cal. Br. 39, this history does not speak to what Congress would have intended if, in addition to the mandate's penalty, the mandate itself were invalidated *along with* the guaranteed-issue and community-rating provisions. On that question, the best guides for this Court's analysis are Congress's express statement that the mandate was essential to the guaranteed-issue and community-rating provisions, and the substantive connections between the various provisions of the ACA recognized by the joint dissenters in *NFIB*.

CONCLUSION

The district court correctly held that the individual mandate is unconstitutional in light of the elimination of its penalty, that the guaranteed-issue and community-rating provisions are inseverable from the mandate, and that the remainder of the ACA is inseverable in turn. Accordingly, the court's judgment should be affirmed on the merits, except insofar as it purports to extend relief to ACA provisions that are unnecessary to remedy plaintiffs' injuries.

Respectfully submitted,

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MAY 2019

CERTIFICATE OF SERVICE

I hereby certify that on May 1, 2019, I electronically filed the foregoing brief with the Clerk of the Court by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

s/August E. Flentje
AUGUST E. FLENTJE

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the word limit of Federal Rule of Appellate Procedure 32(a)(7) because it contains 12,063 words, excluding the parts of the document exempted by Federal Rule of Appellate Procedure 32(f). I further certify that this motion complies with the typeface and type-style requirements of Federal Rules of Appellate Procedure 32(a)(5) and 32(a)(6) because it has been prepared using Microsoft Word 2016 in a proportionally spaced typeface, 14-point Garamond typeface.

s/August E. Flentje
AUGUST E. FLENTJE

ADDENDUM

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26 U.S.C. § 5000A

§ 5000A. Requirement to maintain minimum essential coverage

(a) Requirement to maintain minimum essential coverage.--An applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month.

(b) Shared responsibility payment.--

(1) In general.--If a taxpayer who is an applicable individual, or an applicable individual for whom the taxpayer is liable under paragraph (3), fails to meet the requirement of subsection (a) for 1 or more months, then, except as provided in subsection (e), there is hereby imposed on the taxpayer a penalty with respect to such failures in the amount determined under subsection (c).

(2) Inclusion with return.--Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(3) Payment of penalty.--If an individual with respect to whom a penalty is imposed by this section for any month--

(A) is a dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year including such month, such other taxpayer shall be liable for such penalty, or

(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) Amount of penalty.--

(1) In general.--The amount of the penalty imposed by this section on any taxpayer for any taxable year with respect to failures described in subsection (b)(1) shall be equal to the lesser of--

(A) the sum of the monthly penalty amounts determined under paragraph (2) for months in the taxable year during which 1 or more such failures occurred, or

(B) an amount equal to the national average premium for qualified health plans which have a bronze level of coverage, provide coverage for the applicable family size involved, and are offered through Exchanges for plan years beginning in the calendar year with or within which the taxable year ends.

(2) Monthly penalty amounts.--For purposes of paragraph (1)(A), the monthly penalty amount with respect to any taxpayer for any month during which any failure described in subsection (b)(1) occurred is an amount equal to 1/12 of the greater of the following amounts:

(A) Flat dollar amount.--An amount equal to the lesser of--

(i) the sum of the applicable dollar amounts for all individuals with respect to whom such failure occurred during such month, or

(ii) 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C)) for the calendar year with or within which the taxable year ends.

(B) Percentage of income.--An amount equal to the following percentage of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer for the taxable year:

(i) 1.0 percent for taxable years beginning in 2014.

(ii) 2.0 percent for taxable years beginning in 2015.

(iii) Zero percent for taxable years beginning after 2015.

(3) Applicable dollar amount.--For purposes of paragraph (1)--

(A) In general.--Except as provided in subparagraphs (B) and (C), the applicable dollar amount is $0.

(B) Phase in.--The applicable dollar amount is $95 for 2014 and $325 for 2015.

(C) Special rule for individuals under age 18.--If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

[**(D) Repealed.** Pub.L. 115-97, Title I, § 11081(a)(2)(B), Dec. 22, 2017, 131 Stat. 2092]

(4) Terms relating to income and families.--For purposes of this section--

(A) Family size.--The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(B) Household income.--The term "household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of--

(i) the modified adjusted gross income of the taxpayer, plus

(ii) the aggregate modified adjusted gross incomes of all other individuals who--

(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(C) Modified adjusted gross income.--The term "modified adjusted gross income" means adjusted gross income increased by—

(i) any amount excluded from gross income under section 911, and

(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

[(D) Repealed. Pub.L. 111-152, Title I, § 1002(b)(1), Mar. 30, 2010, 124 Stat. 1032]

(d) Applicable individual.--For purposes of this section--

(1) In general.--The term "applicable individual" means, with respect to any month, an individual other than an individual described in paragraph (2), (3), or (4).

(2) Religious exemptions.—

(A) Religious conscience exemptions.--

(i) In general.--Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act which certifies that--

(I) such individual is a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and is adherent of established tenets or teachings of such sect or division as described in such section; or

(II) such individual is a member of a religious sect or division thereof which is not described in section 1402(g)(1), who relies solely on a religious method of healing, and for whom the acceptance of medical health services would be inconsistent with the religious beliefs of the individual.

(ii) Special rules.--

(I) Medical health services defined.--For purposes of this subparagraph, the term "medical health services" does not include routine dental, vision and hearing services, midwifery services, vaccinations, necessary medical services provided to children, services required by law or by a third party, and such other services as the Secretary of Health and Human Services may provide in implementing section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act.

(II) Attestation required.--Clause (i)(II) shall apply to an individual for months in a taxable year only if the information provided by the individual under section 1411(b)(5)(A) of such Act includes an attestation that the individual has not received medical health services during the preceding taxable year.

(B) Health care sharing ministry.--

(i) In general.--Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

(ii) Health care sharing ministry.--The term "health care sharing ministry" means an organization--

(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(III) members of which retain membership even after they develop a medical condition,

(IV) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(3) Individuals not lawfully present.--Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(4) Incarcerated individuals.--Such term shall not include an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(e) Exemptions.--No penalty shall be imposed under subsection (a) with respect to--

(1) Individuals who cannot afford coverage.--

(A) In general.--Any applicable individual for any month if the applicable individual's required contribution (determined on an annual basis) for coverage for the month exceeds 8 percent of such individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act. For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B) Required contribution.--For purposes of this paragraph, the term "required contribution" means--

(i) in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible only to purchase minimum essential coverage described in subsection (f)(1)(C), the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) Special rules for individuals related to employees.--For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (A) shall be made by reference to[1] required contribution of the employee.

(D) Indexing.--In the case of plan years beginning in any calendar year after 2014, subparagraph (A) shall be applied by substituting for "8 percent" the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(2) Taxpayers with income below filing threshold.--Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than the amount of gross income specified in section 6012(a)(1) with respect to the taxpayer.

(3) Members of Indian tribes.--Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(c)(6)).

(4) Months during short coverage gaps.--

(A) In general.--Any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of less than 3 months.

(B) Special rules.--For purposes of applying this paragraph--

(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

(ii) if a continuous period is greater than the period allowed under subparagraph (A), no exception shall be provided under this paragraph for any month in the period, and

(iii) if there is more than 1 continuous period described in subparagraph (A) covering months in a calendar year, the exception provided by this paragraph shall only apply to months in the first of such periods.

The Secretary shall prescribe rules for the collection of the penalty imposed by this section in cases where continuous periods include months in more than 1 taxable year.

(5) Hardships.--Any applicable individual who for any month is determined by the Secretary of Health and Human Services under section 1311(d)(4)(H) to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.

(f) Minimum essential coverage.--For purposes of this section--

(1) In general.--The term "minimum essential coverage" means any of the following:

(A) Government sponsored programs.--Coverage under--

(i) the Medicare program under part A of title XVIII of the Social Security Act,

(ii) the Medicaid program under title XIX of the Social Security Act,

(iii) the CHIP program under title XXI of the Social Security Act or under a qualified CHIP look-alike program (as defined in section 2107(g) of the Social Security Act),

(iv) medical coverage under chapter 55 of title 10, United States Code, including coverage under the TRICARE program;

(v) a health care program under chapter 17 or 18 of title 38, United States Code, as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary,

(vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers);[2] or

(vii) the Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Public Law 103-337; 10 U.S.C. 1587 note).

(B) Employer-sponsored plan.--Coverage under an eligible employer-sponsored plan.

(C) Plans in the individual market.--Coverage under a health plan offered in the individual market within a State.

(D) Grandfathered health plan.--Coverage under a grandfathered health plan.

(E) Other coverage.--Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

(2) Eligible employer-sponsored plan.--The term "eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is--

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

(3) Excepted benefits not treated as minimum essential coverage.--The term "minimum essential coverage" shall not include health insurance coverage which consists of coverage of excepted benefits--

(A) described in paragraph (1) of subsection (c) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(4) Individuals residing outside United States or residents of territories.--Any applicable individual shall be treated as having minimum essential coverage for any month--

(A) if such month occurs during any period described in subparagraph (A) or (B) of section 911(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(5) Insurance-related terms.--Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title.

(g) Administration and procedure.--

(1) In general.--The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) Special rules.--Notwithstanding any other provision of law--

(A) Waiver of criminal penalties.--In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) Limitations on liens and levies.--The Secretary shall not--

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section, or

(ii) levy on any such property with respect to such failure.

42 U.S.C. § 18091

§ 18091. Requirement to maintain minimum essential coverage; findings

Congress makes the following findings:

(1) In general

The individual responsibility requirement provided for in this section (in this section referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(2) Effects on the national economy and interstate commerce

The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased. In the absence of the requirement, some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases financial risks to households and medical providers.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000, or 17.6 percent of the economy, in 2009 to $4,700,000,000,000 in 2019. Private health insurance spending is projected to be $854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) The economy loses up to $207,000,000,000 a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce this economic cost.

(F) The cost of providing uncompensated care to the uninsured was $43,000,000,000 in 2008. To pay for this cost, health care providers pass on the cost to private insurers, which pass on the cost to families. This cost-shifting increases family premiums by on average over $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

(G) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(H) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market.

(I) Under sections 2704 and 2705 of the Public Health Service Act [42 U.S.C. 300gg-3, 300gg-4] (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(J) Administrative costs for private health insurance, which were $90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health

insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) Supreme Court ruling

In United States v. South-Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation.

Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, 131 Stat. 2054 (2017)

Part VIII—Individual Mandate

SEC. 11081. Elimination of Shared Responsibility Payment for Individuals Failing to Maintain Minimum Essential Coverage

(a) IN GENERAL.—Section 5000A(c) is amended—

(1) in paragraph (2)(B)(iii), by striking "2.5 percent" and inserting "Zero percent", and

(2) in paragraph (3)—

(A) by striking "$695" in subparagraph (A) and inserting "$0", and

(B) by striking subparagraph (D).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to months beginning after December 31, 2018.